PRINTED: 05/17/2011 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES	OMB NO. 0938-039				
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMP	LETED	
		155383	B. WING		04/19/2	2011	
NAME OF	PROVIDER OR SUPPLIE	P.	STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	I KOVIDEK OK SOITELE	K	l l	/ WASHINGTON ST			
WASHIN	IGTON HEALTH CA	ARE CENTER	INDIAN	IAPOLIS, IN46231			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
K0000							
	A Life Safety Co	ode Recertification and	K0000	The creation and submiss	ion of		
	State Licensure Survey was conducted by		Rooo	this Plan of Correction do			
	1	e Department of Health in		constitute an admission by	•		
		1 42 CFR 483.70(a).		provider of any conclusion			
	accordance with	142 CTR 403.70(a).		forth in the statement of deficiencies, or of any viol	lation of		
	Survey Date: 04	4/10/11		regulation.This provider	41011 01		
	Survey Date. 0	1 /19/11		respectfully requests that			
	Equility Nymbor	000202		2567 Plan of Correction b			
	Facility Number			considered the Letter of C Allegation and requests a			
	Provider Number: 155383 AIM Number: 100289340			review or post survey visit			
	AIM Number:	100289340		after 5/16/11.			
	Surveyer: Morl	c Caraher, Life Safety					
	Code Specialist	•					
	Code Specialist						
	At this Life Safe	ety Code survey,					
		alth Care Center was					
	found not in con						
	1	or Participation in					
	1 -	caid, 42 CFR Subpart					
	1	Safety from Fire and the					
		the National Fire					
		ciation (NFPA) 101, Life					
	1	SC), Chapter 19, Existing					
	1 '	cupancies and 410 IAC					
	16.2.	Jupaneres una 110 II IC					
	10.2.						
	This one story for	acility was determined to					
	1	11) construction and fully					
		e facility has a fire alarm					
	_	oke detection in the					
	I system with sill	oke actection in the	1	i		1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

corridors, areas open to the corridors and in all resident rooms. The facility has a

> TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MHPP21

Facility ID:

000393

PRINTED: 05/17/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	A. BUILDING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/19/2011
		100000	B. WING	T ADDRESS, CITY, STATE, ZIP CODE	04/13/2011
NAME OF F	ROVIDER OR SUPPLIER			W WASHINGTON ST	
WASHIN	GTON HEALTH CA	RE CENTER	INDIA	ANAPOLIS, IN46231	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE COMPLETION DATE
	capacity of 94 and had a census of 84 at the time of this visit.				
Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 04/27/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:					
K0021 SS=E	enclosure, horizon hazardous area er by devices arrange	t passageway, stairway Ital exit, smoke barrier or Inclosure is held open only ed to automatically close all Ite or throughout the facility			
	a) the required ma	inual fire alarm system;			
	smoke passing thr	rectors designed to detect rough the opening or a etection system; and			
	19.2.2.2.6, 7.2.1.8 Based on observation facility failed to observing hazardou was held open or to automatically upon activation of this deficient practice.	prinkler system, if installed. 3.2 ation and interview, the ensure 1 of 3 doors as areas such as a kitchen ally by a device arranged close the door, or close it of the fire alarm system. actice affects kitchen staff I visitors in the main	K0021	What corrective action(s) will accomplished for those resid found to have been affected the deficient practice?The kit door to the dining room was updated with automatic clost with activation of fire alarm system.How will you identify residents having the potentia be affected by the same defipractice and what corrective	lents by tchen ure other al to cient

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MHPP21 Facility ID: 000393

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li ´					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPLETED
		155383	B. WING			04/19/2011
			-	STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				WASHINGTON ST	
WASHIN	GTON HEALTH CAI	RE CENTER			APOLIS, IN46231	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	-	ID		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPRIA		DATE
	dining room	,			action will be taken?Residen	ts
TAG	dining room. Findings include: Based on observation and acknowledge.	ation with the ector during a tour of the 45 a.m. to 1:10 p.m., the ne main dining room was por stop which would not close automatically, or of the fire alarm system. ew at the time of Maintenance Director n door to the main dining open by a device matically close the door of the fire alarm system ed a door stop was used en door to the main		TAG	action will be taken?Resident currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. We measures will be put into place what systematic changes will make to ensure that the deficient practice does not recur?Door stop was removed from the kitchen door. In accordance fire alarm testing, maintenant director or designee will ensure proper functioning of doors recquiring automatice closure with activation of fire alarm system. How the corrective action(s) will be monitored to ensure the deficient practice not recur, i.e. what quality assurance program will be purinto place?A CQI tool for Life Safety Review will be util weekly x 4, monthly x 2, and quarterly thereafter. The CQ Committee will review the dathreshold is not achieved, an action plan will be developed.	bate ts hat ce or lyou cient with ce ure will ut lized I ta. If
FORM CMS-2	567(02-99) Previous Version	ns Obsolete Event ID:	/IHPP21	Facility I	D: 000393 If continuation sh	neet Page 3 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155383 04/19/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8201 W WASHINGTON ST WASHINGTON HEALTH CARE CENTER INDIANAPOLIS, IN46231 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE K0025 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in SS=E accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3. 19.3.7.5. 19.1.6.3. 19.1.6.4 Based on observation and interview, the What corrective action(s) will be K0025 05/16/2011 accomplished for those Residents facility failed to ensure 1 of 1 openings found to have been affected by through the ceiling into the attic above the the deficient practice? The 8 Boiler room and 1 of 1 openings through inch opening in ceiling in boiler room, and the 6 inch opening in the ceiling into the attic above the Family the Family Conference Room Conference room storage were maintained storage room were repaired and to provide at least a one half hour fire firestopped on 4/22/11 by resistance rating. This deficient practice maintenance staff. A building review was completed on 5/6/11 could affect any resident, staff or visitor in with no further concerns in smoke the vicinity of the Boiler room and the barriers identified. How will you Family Conference room. identify other Residents having the potential to be affected by the same deficient Findings include: practice? Residents currently living in the facility, visitors, and Based on observations with the staff have the potential to be Maintenance Director during a tour of the affected by the alleged deficient facility from 10:45 a.m. to 1:10 p.m. on practice. What measures will be put into place or what systematic 04/19/11, there is an eight inch diameter changes you will make to ensure hole in the ceiling in the Boiler room that the deficient practice does which is not firestopped. Based on not recur? When renovation or interview at the time of observation, the repairs occur in the future, facility will review areas to ensure these Maintenance Director stated furnace areas are maintained to provide ductwork used to pass through the ceiling at least a one half hour fire in the boiler room but has been taken out, resistance ratinig. Another

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ((X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155383	B. WINC		<u> </u>	04/19/2	011
			D. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				WASHINGTON ST		
WASHIN	GTON HEALTH CA	RE CENTER	INDIANAPOLIS, IN46231				
					711 OLIO, 11440201		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	_	ed the eight inch opening			building review will be condu		
	is not firestopped.			by 5/16/11 to ensure no further concern in smoke barriers.How			
Based on observation with the Maintenance Director during a tour of the				the corrective action(s) will b			
				monitored to ensure the defic			
	facility from 10:4	45 a.m. to 1:10 p.m. on			practice will not recur, i.e. wh		
04/19/11, the Family Conference room				quality assurance program w			
	· ·	•			put into place? A CQI tool fo		
storage room has one opening in the ceiling measuring six inches in diameter. Based on interview at the time of observation, the Maintenance Director stated a previous water leak into the building caused the opening in the ceiling					Life Safety Review will be uti	lized	
		_			weekly x 4, monthly x 2, and	,	
					quarterly thereafter. The CQ Committee will review the da		
					threshold is not achieved, an		
					action plan will be developed		
		the opening in the ceiling			·		
	and acknowledge	ed the six inch diameter					
	opening in the Fa	amily Conference room					
	storage room is n						
	storage room is i	iot in estopped.					
	2.1.10(%)						
	3.1-19(b)						
K0029	One hour fire rated	d construction (with ¾ hour	ł				
SS=E		r an approved automatic fire					
00-L		em in accordance with 8.4.1					
		otects hazardous areas.					
	When the approve	ed automatic fire					
		em option is used, the areas					
	· ·	n other spaces by smoke					
		and doors. Doors are					
		on-rated or field-applied hat do not exceed 48 inches					
		f the door are permitted.					
	19.3.2.1	inc door are permitted.					
		ation and interview, the	KO	029	What corrective action(s) will	be	05/16/2011
		ensure 1 of 1 doors	150	5 <u>2</u> 5	accomplished for those Resi		
	-				found to have been affected by the deficient practice?A new self-closing device was installed		
	_	is areas such as a soiled					
	utility room used	I for trash collection is					
					on the soiled utility room doo	r on	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	01	COMPL	ETED
		155383	B. WING			04/19/2	011
NAME OF F	AD CAMPED OR GARDA IED				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			8201 W	WASHINGTON ST		
	GTON HEALTH CA	RE CENTER			APOLIS, IN46231		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re l	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	 	TAG			DATE
		elf closing devices on the			the Memory Care unit on 4/22/11. How will you identify		
		ient practice could affect			Residents having the potential		
	any resident, staff or visitor in the vicinity				be affected by the same defic		
	of Memory Care	soiled utility room.			practice? Residents currentl	-	
	Findings include	:			living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practiceWhat measures will be		
	Based on observa	ation with the			put into place or what system		
	Maintenance Dir	rector during a tour of the			changes you will make to en	sure	
facility from 10:45 a m to 1:10 n m on that the deficient practice d							
	04/19/11, the Memory Care soiled utility room was being used to store one thirty				not recur? A review of all soils		
					utility room doors was perform on 5/6/11. Another review with		
	_	filled with trash and the			completed on 5/16/11 to ensi		
	_	soiled utility room is not			proper functioning of soiled u		
		self closing device.			room doors to have self-closi	ing	
	Based on intervie	<u> </u>			device. How the corrective		
		Maintenance Director			action(s) will be monitored to ensure the deficient practice		
		e Memory Care soiled			not recur, i.e. what quality	vv	
	_	•			assurance program will be pu	ut	
	-	being used to store trash			into place?A CQI tool for		
	_	or is not equipped with a			Life Safety Review will be uti		
	self closing device	ce.			weekly x 4, monthly x 2, and quarterly thereafter. The CQ		
	3.1-19(b)				Committee will review the da threshold is not achieved, an action plan will be developed	ta. If	
K0038 SS=E	readily accessible with section 7.1.	anged so that exits are at all times in accordance			Ma 1		
		ation and interview, the	K00)38	What corrective action(s) will		05/16/2011
	•	ensure the means of			accomplished for those Residual found to have been affected		
		of 7 exits was readily			the deficient practice?Exit access		
	accessible for res	sidents without a clinical			code was posted at employe	e	
	diagnosis requiri	ng specialized security			exit. How will you identify other		
	measures. LSC	19.2.2.2.4 requires doors			Residents having the potential	ai to	

li '		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLE		
		155383	B. WIN			04/19/20)11	
NAME OF	PROVIDER OR SUPPLIEI	- {		1	ADDRESS, CITY, STATE, ZIP CODE			
\ ^ / ^ O! !!!		DE OENTED		8201 W WASHINGTON ST				
WASHIN	IGTON HEALTH CA	RE CENTER		INDIAN	APOLIS, IN46231			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-:	DATE	
	1 ^	d means of egress shall			be affected by the same defi practice? Residents current			
		with a latch or lock that			living in the facility, visitors, and			
	_	of a tool or key from the			staff have the potential to be			
	1 -	ception No. 1 requires			affected by the alleged defici			
		angements without			practiceWhat measures will			
		hall be permitted in health			put into place or what systen changes you will make to en			
	1 ^	s, or portions of health			that the deficient practice do			
	1	s, where the clinical needs			not recur? When renovation	or		
		require specialized			repairs occur in the future, fa	, ,		
	security measures for their safety,				will review areas to ensure the			
	provided that staff can readily unlock such doors at all times. This deficient practice				exit access is arranged so the exits are readily accessible a			
					times. How the corrective			
	affects any resid	ent, staff or visitor			action(s) will be monitored to			
	needing to exit t	he facility through the			ensure the deficient practice	will		
	employee exit.				not recur, i.e. what quality assurance program will be p			
					into place?A CQI tool for			
	Findings include	· ·			Life Safety Review will be uti			
					weekly x 4, monthly x 2, and			
	Based on observ	rations with the			quarterly thereafter. The CC			
	Maintenance Di	rector during a tour of the			Committee will review the da threshold is not achieved, an			
	1	45 a.m. to 1:10 p.m. on			action plan will be developed			
	· ·	t doors are magnetically			'			
		d be opened by entering a						
	1	The exit access code was						
	posted at all exit							
	1 ^	hich is marked with an						
		occupants in the facility						
	1 -	Care exit. Based on						
	1	the exit conference at						
	1	19/11, the Administrator						
	_	near the Memory Care						
		cal diagnosis requiring						
		rity measures and						
	1 -	-						
	acknowledged th	ne exit access code is not						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155383 04/19/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8201 W WASHINGTON ST WASHINGTON HEALTH CARE CENTER INDIANAPOLIS, IN46231 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE posted at the Memory Care exit but the employee exit is an exit for all occupants in the facility and acknowledged the exit access code was not posted at the employee exit. 3.1-19(b)Emergency lighting of at least 11/2 hour K0046 duration is provided in accordance with 7.9. SS=E 19.2.9.1. What corrective action(s) will be Based on observation, record review and K0046 05/16/2011 accomplished for those Residents interview; the facility failed to document found to have been affected by testing of emergency lighting in the deficient practice?Battery accordance with LSC 7.9 for 3 of 3 operated emergency lights test log implemented with testing to battery operated emergency lights. LSC be completed by 5/16/11. How will 7.9.3, Periodic Testing of Emergency you identify other Residents Lighting Equipment, requires a functional having the potential to be affected test to be conducted at 30 day intervals by the same deficient practice? Residents currently living in the and an annual test to be conducted on facility, visitors, and staff have the every required battery powered potential to be affected by the emergency lighting system for not less alleged deficient practiceWhat than a 1 ½-hour duration. Equipment measures will be put into place or what systematic changes you will shall be fully operational for the duration make to ensure that the deficient of the test. Written records of visual practice does not recur?Battery inspections and tests shall be kept by the Operated Lights Test Log owner for inspection by the authority implemented and will be having jurisdiction. This deficient completed by maintenance staff monthly. How the corrective practice could affect all occupants in the action(s) will be monitored to facility including staff, visitors and ensure the deficient practice will residents. not recur, i.e. what quality assurance program will be put

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Event ID:

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Facility ID:

000393

If continuation sheet

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE S COMPL 04/19/20	ETED
	ROVIDER OR SUPPLIER GTON HEALTH CAI		P. W.	STREET A	DDRESS, CITY, STATE, ZIP CODE WASHINGTON ST APOLIS, IN46231		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re	(X5) COMPLETION DATE
	Based on observation Maintenance Direction 10:404/19/11, there are emergency lights Based on record Maintenance Direction 10:45 a.m. on 04. Emergency Lights 2010" documents functional testing battery operated period April 2010 log of thirty day or annual testing emergency light duration for 2011 review. Based or observation, the lacknowledged at 2011 thirty day in for each of the th	ations with the ector during a tour of the 45 a.m. to 1:10 p.m. on re three battery operated located in the facility. review with the ector from 9:30 a.m. to /19/11, "Battery Operated ts Test Log for (Year): a thirty day interval g for each of the three emergency lights for the 0 to December 2010. A interval functional testing for each battery operated for not less than 1 ½-hour was not available for an interview at the time of Maintenance Director log of January to March interval or annual testing ree battery operated in the facility was not			into place? A CQI tool for Life Safety Review will be uti monthly to ensure completion battery operated lights testin. The CQI Committee will reviet the data. If threshold is not achieved, an action plan will developed.	n of g. ew	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE S COMPL 04/19/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON HEALTH CAI	RE CENTER		I	WASHINGTON ST APOLIS, IN46231		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	COMPLETION DATE	
K0069 SS=E	with 9.2.3. 19.3. Based on record observation; the of 1 kitchen exhat at least semiannu Edition, Standard and Fire Protection Cooking Operating grease removal dother appurtenant bare metal at free surfaces becoming with grease or oil exhaust system is shall not be coated substance. The exhall be inspected qualified, and company is affect any resident vicinity of the kitch Findings included Based on record Maintenance Director 10:45 a.m. on 04. Company "Service documentation in the standard process of the service of the servic	review with the ector from 9:30 a.m. to /19/11, Fire Safety	KO	0069	What corrective action(s) will accomplished for those Resign found to have been affected the deficient practice? Documentation of semiannual kitchen exhaust cleanings will be maintained facility. How will you identify on Residents having the potential be affected by the same defining in the facility, visitors, a staff have the potential to be affected by the alleged deficing practice. What measures will be put into place or what system changes you will make to ensure the deficient practice do not recur? Documentation of semiannual kitchen exhaust cleanings will be maintained the facility, and will be kept in books in maintenance office dietary office. How the correct action(s) will be monitored to ensure the deficient practice not recur, i.e. what quality assurance program will be put into place? A CQI tool for Life Safety Review will be utility assurance documentation in place. The CQI Committee will review the data. If threshold is not achie an action plan will be develop	dents by in other al to cient y ind ent oe natic sure es in n log and ctive will ut lized rterly es is es es es	05/16/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155383	A. BUILDING B. WING		04/19/2011
	PROVIDER OR SUPPLIER GTON HEALTH CAI		STREE 8201	T ADDRESS, CITY, STATE, ZIP CODE W WASHINGTON ST ANAPOLIS, IN46231	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	semiannual clean 2011 was availab interview at the t Maintenance Director of semians system cleaning p was available for observation with Director during a 10:45 a.m. to 1:1 sticker tag on the hood listed the m performed in Feb	tour of the facility from 10 p.m. on 04/19/11, a kitchen exhaust system lost recent cleaning was bruary 2011 but no other notation was found on the			
K0144 SS=F	exercised under lo month in accordant 3.4.4.1. 1. Based on reco the facility failed percentage for the the generator for 3-4.4.1.1 of NFP, testing of generate emergency electric	ord review and interview, to document the load e monthly load test for 1 of 12 months. Chapter A 99 requires monthly	K0144	What corrective action(s) wil accomplished for those Resi found to have been affected the deficient practice?Month load testing will include recordings of the percentage capacity and minimum exhal gas temperatures. A general remote annuciator to be installed.How will you identify	dents by ly e load ust tor

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MHPP21 Facility ID: 000393 If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155383 04/19/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8201 W WASHINGTON ST WASHINGTON HEALTH CARE CENTER INDIANAPOLIS, IN46231 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 6-4.2 of NFPA 110 requires generator sets other Residents having the potential to be affected by the in Level 1 and Level 2 service to be same deficient practice? exercised at least once monthly, for a Residents currently living in the minimum of 30 minutes, using one of the facility, visitors, and staff have the potential to be affected by the following methods: alleged deficient practice.What a. Under operating temperature conditions measures will be put into place or or at not less than 30 percent of the EPS what systematic changes you will (Emergency Power Supply) nameplate make to ensure that the deficient practice does not rating. recur?Emergency generator b. Loading that maintains the minimum excercising/load Testing will be exhaust gas temperatures as completed and recorded recommended by the manufacturer. monthly. The Emergency The date and time of day for required Generator Excercising/Load Testing log will include recordings testing shall be decided by the owner, for percentage load capacity and based on facility operations. This minimum exhaust gas deficient practice could affect all temperatures. How the corrective action(s) will be monitored to residents, staff and visitors. ensure the deficient practice will not recur, i.e. what quality Findings include: assurance program will be put into place? A CQI tool for Based on review of "Emergency Life Safety Review will be utilized weekly x 4 and monthly Generator Exercising/Load Testing" thereafter. The CQI Committee monthly load test documentation with the will review the data. If threshold Maintenance Director from 9:30 a.m. to is not achieved, an action plan will 10:45 a.m. on 04/19/11, monthly be developed. generator load testing documented on 02/04/11 and 02/28/11 show the emergency generator ran for at least thirty minutes during each documented load test but neither the percentage of load capacity or minimum exhaust gas temperature was recorded. Based on interview at the time of record review, the Maintenance Director stated the facility had a power

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 01	(X3) DATE: COMPL 04/19/2	ETED
	PROVIDER OR SUPPLIER		p. wire	STREET A	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST APOLIS, IN46231	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	(X5) COMPLETION DATE
	caused the emergoperated and the each of those dat monthly load tes. Director acknow percentage of loa exhaust gas temp during February testing. 3.1-19(b) 2. Based on obset the facility failed annunciator panergenerator would alarm conditions NFPA 99, 1999 Fealth Care Faci 3-4.1.1.15 require to be provided in observed by open regular work statishall indicate ala emergency or autifollows: a. Individual visu the following: 1. When the emergenerator would alarm conditions not served by open regular work statishall indicate ala emergency or autifollows:	els for the emergency alert staff to generator in accordance with Edition, Standard for lities. NFPA 99, Section es a remote annunciator a location readily rating personnel at a ion. The annunciator rm conditions of the exiliary power source as all signals shall indicate rgency or auxiliary operating to supply power					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155383	A. BUI	LDING	01	04/19/2	
		133303	B. WIN			04/13/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST		
WASHIN	GTON HEALTH CA	RE CENTER		1	APOLIS, IN46231		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
	b. Individual visi	C 1					
		signal to warn of an					
		alarm condition shall					
	indicate the follo	•					
	1. Low lubricating	• •					
		nperature (below those					
	required in 3-4.1						
	3. Excessive wat	-					
		en the main fuel storage					
	tank contains less than a 3-hour operating						
	supply						
	5. Overcrank (failed to start)						
	6. Overspeed						
	_	work station will be					
	^	dically, an audible and					
	visual derangeme	ent signal, appropriately					
	labeled, shall be	established at a					
	continuously mo	nitored location. This					
	derangement sign	nal shall activate when					
	any of the condit	ions in 3-4.1.1.15(a) and					
	(b) occur, but nee	ed not display these					
	conditions indivi	dually. This deficient					
	practice could af	fect all occupants in the					
	facility including	residents, staff and					
	visitors.						
	Findings include	:					
	Based on observa	ation with the					
		rector during a tour of the					
	facility from 10:4	45 a.m. to 1:10 p.m. on					
	04/19/11, the fac	ility has one emergency					
	generator annunc	ciator panel located across					
	the hall from the	300 Hall nurse's station					

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/19/2011
	PROVIDER OR SUPPLIER		8201 W	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST APOLIS, IN46231	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	switch which wa Based on intervi- observation, the acknowledged the annunciator panel position and state the annunciator p	tor panel has a toggle in the off position. Every at the time of Maintenance Director are emergency generator elected witch was in the off every determined and the audible alarm for boanel would not sound to toggle switch is in the off			